MARICOPA HEALTH SYSTEM

Count on us to care.

Please complete all fields that apply to your requested services
**

REFERRAL REOUISITION

Patient Name:_____

Circle Plan: **Health Select** **Kids Care** **Maricopa Health Plan**

Maricopa Senior Select **Maricopa Long Term Care Plan**

Social Sec. #:_____

Patient ID #:_____

Patient Sex:_____ **Date of Birth:**_____

Patient Tele. #:_____

Patient Address :_____

APPOINTMENT DESK PHONE 602-344-1015
APPOINTMENT DESK FAX 602-344-1143
Please fax Radiology referrals to **602-344-1313**
Please fax Vascular referrals to **602 344 1214**
Please fax PT/OT/ST referrals to **602-344-1297**

To be completed by referring Clinic/Physician

Referring Provider Information

Name of Referring Physician:_____

Name of Referral Contact:_____

Clinic/Physician Phone #:_____

Clinic/Physician Fax #:_____

Referring Clinic Location/Physician Address:

_____

_____

_____

* Required if request is being made by, other than ordering Physician

*Referring Clinic:_____

*Attending Physician:_____

*Ordering PAS #:_____

*Attending PAS #:_____

Copy to: Referring Physician *(Authorizing signature on file),*
Other:_____

To be completed by referring Clinic/Physician

Service / Procedure or Consultation Desired:

Pertinent Medical History:
(Required for all specialty consultations.
Please include patient medications.)

Reason for Service / Procedure or Consultation:
(i.e. Specific information required)

Dx Code: ☐

Visit Priority: **Urgent** **Routine**

(Please check one) (24 hours) ☐ (2-3 days) ☐ (next available) ☐

Physician Signature:_____ **Date:**_____

(To be completed by the Appointment Desk)

Appointment set by:_____**Date**__-__-__

Comments:_____

_____

_____

Appointment Date____-____-____
Time _____:____ **AM**___ **PM**___
Doctor/Clinic referred to & phone #
_____

If Medicare Eligible Patient: Is ABN Required? Yes No Was ABN Signed? Yes No